

CLAIM VERIFICATION SYSTEM

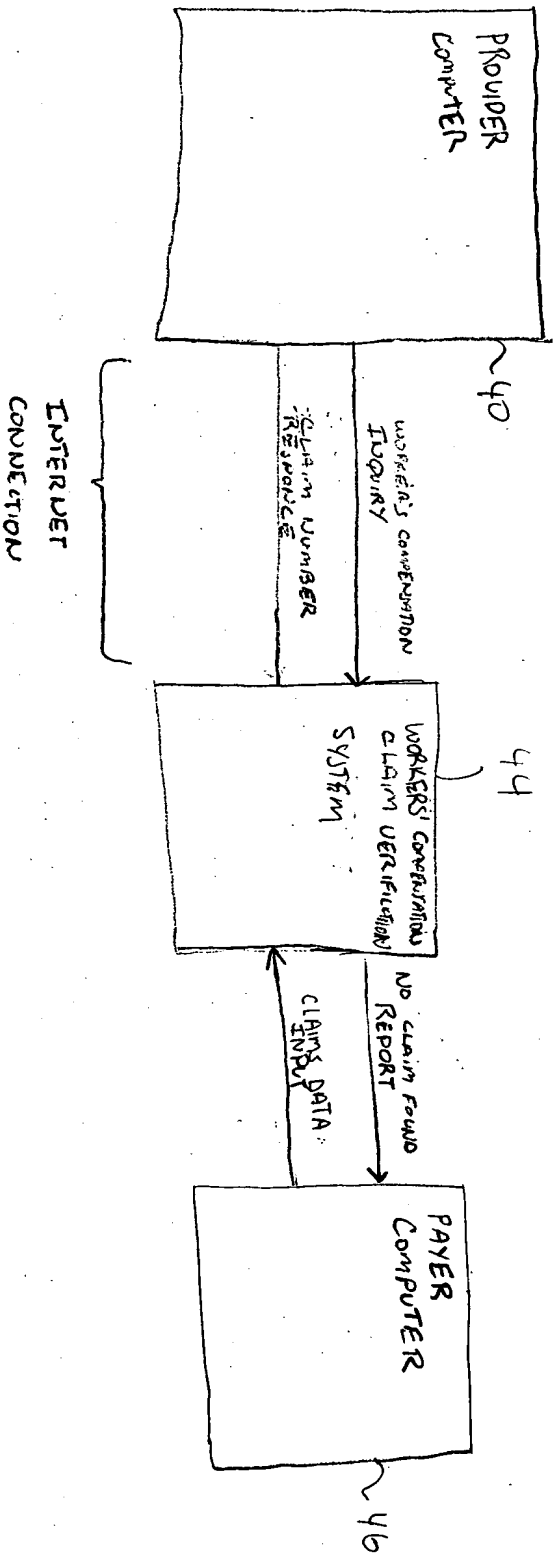
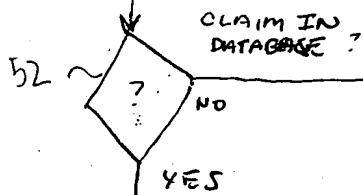


FIGURE 1

PROVIDER USING SOFTWARE
PROGRAM SENDS AN
ELECTRONIC INQUIRY
REQUEST ACROSS INTERNET
TO CLAIM VERIFICATION
DATABASE SYSTEM

~ 50



54 ~

CLAIM VERIFICATION DATABASE
SYSTEM AUTOMATICALLY
SENDS INDICATION OF
WORKERS' COMPENSATION
CLAIM NUMBER TO
PROVIDER

56 ~

PROVIDER CAN NOW
PROVIDE REPORT FOR
PAYER CONTAINING CORRECT
WORKERS' COMPENSATION
CLAIM NUMBER

CLAIM VERIFICATION DATABASE
SYSTEM AUTOMATICALLY
SENDS REPORT TO
PAYER

~ 56

PAYER PROMPTS EMPLOYER
TO REPORT INJURY

~ 58

FIGURE 2

WORKER'S COMPENSATION
MEDICAL TREATMENT REPORTING

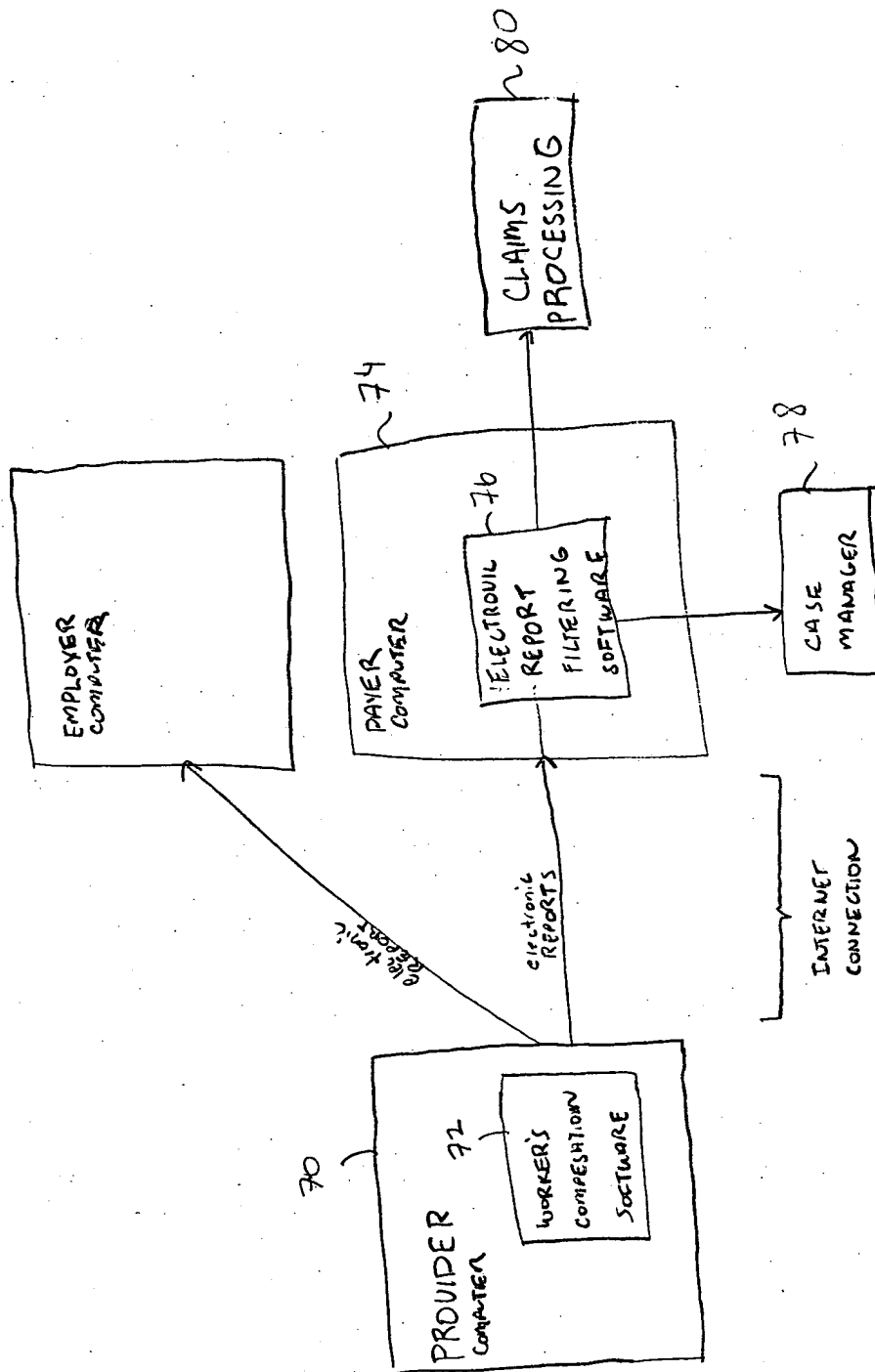


FIGURE 3

PROVIDER FILLS OUT REPORT FORM
USING SOFTWARE; FORM CONTAINS
ALL REQUIRED DATA FIELDS ~ 90

ELECTRONIC REPORT SENT TO
PAYER ~ 92

SOFTWARE AT THE PAYER
EXAMINES THE ELECTRONIC
REPORT TO AUTOMATICALLY
SELECT REPORTS TO SEND TO
A CASE MANAGER ~ 94

SELECTED REPORTS SENT TO
CASE MANAGER FOR HUMAN
REVIEW ~ 96

FIGURE 4

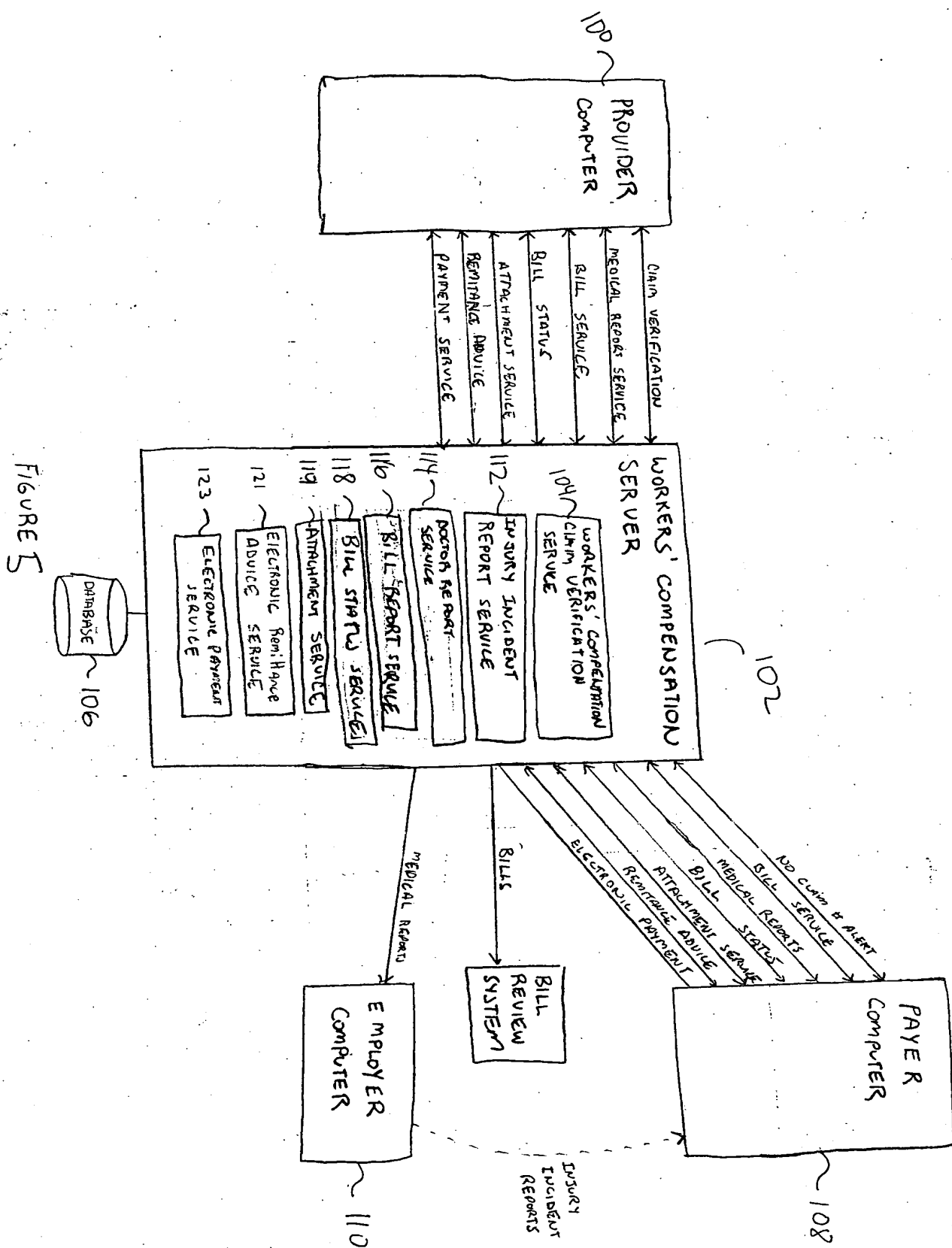


FIGURE 5

[illegible]

First Report (Input Form)

Main Forms Entry Entry View Reports Latest Received Reports E-Mail New Patients Evidence Tables Administration Help



Patient	History	Findings	Diagnosis	Treatment	Work Status	User Fields
Patient Information: LName ANDERSON FName JIM SSN# 494-94-9494 DOB 10/16/1999 Report Date: 10/21/1999						
Injury Information: 12. Injured at Address: 234 CONTRA COSTA BLVD City CONCORD State CA Zipcode 94549-3003 County CONTRA COSTA 13. Date and hour of injury or onset of illness: 10/16/1999 08:00 AM PM 14. Date Last Worked: 10/16/1999 15. Date and hour of first examination or treatment: 10/17/1999 03:00 AM PM 16. Have you (or your office) previously treated patient? Yes No 16a. Treated under any health plan for this incident? Yes No 16b. Health Plan Name: BLUE CROSS						
17. Patient's Description of how the Accident or Exposure Occurred: A. Description: LIFTING A 40# PRODUCE BOX FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN B. Relevant Past History: RECURRENT LUMBAR/SACRAL STRAINS C. Description of present occupational duties: Heavy Lifting D. Relevant leisure activities: WEEKEND FOOTBALL, SKIING, SAILING E. Does employee have 2nd job? Yes No If yes, Employer Name: MT ROSE SKI RESORT						

for Workers' Compensation

Save OK Ykdate View Print OK to Send Suspend Delete Cancel

Doctor's First Report

Start StellarForm5021 - Microsoft

StellarNet Worker's Comp

Date and Time: 10/21/99 10:11:01 AM

10:18 AM

FIGURE 6

Report Page 1

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Page 1 of 2

STATE OF CALIFORNIA
Form 100-100 (Rev. 10/99)

Form ID: INS000010000002

1. INSURER NAME AND ADDRESS

INSURER: 123 COAST DRIVE, SAN FRANCISCO, CA 94103
Telephone Number: 415-339-3939

1b. Citation #

REPORT DATE
10/17/99

2. EMPLOYER NAME

EMPLOYER: 204 MARINA WAY
SAN LEANDRO, CA 94589-0909
Telephone Number: 510-393-9393

3. Address No and Street
City State Zip
SAN LEANDRO CA 94589-0909

4. Nature of Business/STORY STORE

Policy Number: 404-4-494

5. PATIENT NAME

JIM ANDERSON

6. Sex
☐ Male ☐ Female

7. Date of Birth
Mo Day Year
10 14 1969

8. Address

1744 BELLE VALLEY RD
JOURNEVALAN CLERK

City State Zip
LAFAYETTE CA 94588-8888

9. Home Tel #
925-888-8888

10. Occupation (Spec. Job)

11a. Social Security #
404-4-494

11b. Date of Hire
10/23/1994

11c. Patient Account #
945-4-494

12. Injured At

204 CONTRA COSTA BLD

City State Zip
CONCORD CA 94520-0000

County
CONTRA COSTA

13. Date and Hour of Injury

Mo Day Year Hour Minute
10 16 1999 08:30 AM

14. Date Last Worked
Mo Day Year
10 16 1999

15. Date and Hour of First Examination or Treatment

Mo Day Year Hour Minute
10 17 1999 09:00 AM

16. Have you (or your office) previously treated Patient? ☐ Yes ☐ No

16a. Health Plan Name: BLUE CROSS

17. PATIENT'S DESCRIPTION OF HOW THE ACCIDENT OR EXPOSURE OCCURRED:

A. Description: LIFTING A BOX FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN

B. Relevant Past History: RECURRENT LUMBOSACRAL STRAINS

C. Description of Present Occupational Duties:
Heavy Lifting

D. Relevant Leisure Activities/WEEKEND FOOTBALL, SKING, SAILING

E. Does Employee have 2nd job? ☐ Yes ☐ No If yes, Employer Name: MT ROSE SKI RESORT

18. SUBJECTIVE COMPLAINTS:

A. Description: SHARP LOW BACK PAIN

B. Symptoms:
Body Part: Lower Back
Onset: Sudden
Quality: Sharp
Frequency: Constant
Severity: Moderate
Provoking Activities: Lifting/Descending/Sliding

19. OBJECTIVE FINDINGS:

A. Vital Signs:
HR: 78
BP: 120/80
Wt: 190
Pulse: 78
Temp: 98.6
Resps: 18
Min

B. Neurological Exam:
4/5 DEGREES LUMBOSACRAL PAIN WITH POSITIVE RIGHT STRAIGHT LEG RAISE AT 60 DEGREES

C. X-Ray and Laboratory Results:
NONE

D. Job Description Reviewed: ☐ Yes ☐ No

20. DIAGNOSIS: (specify date, grade, degree, extent and duration of episode)

A. Description:
STRAIN LUMBOSACRAL
C. Chemical or Toxic Component Involved? ☐ Yes ☐ No
If yes, explain:
D. Other Relevant Diagnosis

21. ARE FINDINGS AND DIAGNOSIS CONSISTENT WITH PATIENT'S ACCOUNT OF INJURY OR ONSET OF ILLNESS? ☐ Yes ☐ No

If no, explain:
A. Did work cause or contribute to the injury or illness? ☐ Yes ☐ No ☐ Cannot determine
If no or cannot determine, explain:

FILED
7A

Report Page 2

--- CONTINUED DOCTOR'S FIRST REPORT OF INJURY --- ANDERSON, JIM 494-94394

Page 2 of 2

B. Is the patient permanent and stationary? ☐ Yes ☒ No If yes, Date:

C. If no, estimated permanent and stationary date: 11/03/99

D. Is permanent disability anticipated? ☐ Yes ☒ No ☐ Yes ☐ No

22. IS THERE ANY OTHER CURRENT CONDITION THAT WILL DELAY PATIENT'S RECOVERY? ☐ Yes ☒ No

If yes, specify: None injury to same body part

23. TREATMENT RENDERED:

A. First Aid: ☐ Yes ☒ No

B. Treatment Date: OFFICE/OUTPATIENT VISIT, EST 10/17/99

D. Instructions to Patient: ECONOMIC EDUCATION, HEAT AND LOW BACK EXERCISES

E. Referrals:

F. Disability status: Discharged as cured, with no need for further medical care? ☐ Yes ☒ No

G. If discharged, Discharge Date:

24. IS FURTHER TREATMENT REQUIRED? ☒ Yes ☐ No

A. Medication: VICODIN

C. If Surgery, type:

D. Diagnostic Tests:

E. Estimated Duration of Treatment: 25 days

C. Recommended Referrals:

H. Treatment Plan, Other:

25. IF HOSPITALIZED AS INPATIENT, Give Hospital Name and Location:

26. WORK STATUS:

A. Is Patient able to Perform Usual Work? ☐ Yes ☒ No

B. If not, date when patient can return to Regular Work: 10/26/99

C. If not, date when patient can return to Modified/Transitional work: 10/20/99

D. Restrictions: Specific functional limitations (range) and weight restrictions based on an 8 hour work day:

Key: (U) Usual, (S) Severe, (O) Occasional 1-33%, (F) Frequent 34%-66%, (C) Continuous 67%-100%

Activity: Repetitive Bending

Lifting From Floor

Lifting From Waist

Frequency: Occasional 1-33%

Weight Limit: 50 lbs

MAX Lbs

E. Restrict class Narrative:

F. Is employee likely to become a Qualified Injured Worker? ☐ Yes ☒ No

27. Doctor's Name and Degree: CLIFF L. WILSON, MD

Facility Name: FIRST CARE

Address: 121 TAYLOR ST., LAFAVETTE, CA 94549-8880

Doctor's Telephone #: 925-384-8305

IRS #: 393934481

CA License #: CA238193483

Specialty: OCC MED

Pro Network:

<<< DOCTOR'S SIGNATURE ON FILE AT DOCTOR'S OFFICE >>>

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or delaying worker's compensation benefits or payments is guilty of a felony.

Input Form

Claims Verification Service - Microsoft Internet Explorer

File Edit View Go Favorites Help

Back Forward Stop Refresh Home Search Favorites History Channels Fullscreen Mail Print

Address http://216.103.197.67/stellarnet/patient/claimVerInput/claim_form.asp

Links [Best of the Web](#) [Channel Guide](#) [Customer Links](#) [Internet Explorer News](#) [Internet Start](#) [RealPlayer](#)

e-Stellarnet

Claims Verification Service

Enter Patient details (All fields are required.)

[Click here for batch verification.](#)

Last Name :	<input type="text" value="SMITH"/>	First Name :	<input type="text" value="Sue"/>
SSN :	<input type="text" value="565340665"/>	Date of Injury :	<input type="text" value="10-24-1999"/>
Employer :	<input type="text" value="Railway Express"/>	Payer Name :	<input type="text" value="CSSG"/>

[Back](#) [Home](#) [Dental Menu](#)

Result Page

Claims Verification Service - Microsoft Internet Explorer

File Edit View Go Favorites Help

Back Forward Stop Refresh Home Search Favorites History Channels Fullscreen Mail Print

Address: http://216.103.197.67/stellarnet/patient/claim/verifyinput/display_details.asp

[Back](#) [Best of the Web](#) [Channel Guide](#) [Customer Links](#) [Internet Explorer News](#) [Internet Start](#) [Read Page](#)

e-StellarNet

Claims Verification Service

Patient details

Last Name: SMITH

SSN: 565340665

Employer: Railway Express

Payer Name: CSSG

Status: ☒ Accepted ☐ Rejected ☐ Delayed

First Name: Sue

Date of Injury: 10/24/99

Claim Number: CA334848399

Payer ID: WCO34

[Click here to perform another lookup.](#)

[Back](#) [Home](#) [Demo Menu](#)

Start [eX](#) [eX](#) [eX](#) [eX](#) [eX](#)

Exploring - stel...

Inbox - Outlook

Business Intr...

Microsoft Acc...

Claims Verif...

1:41 PM

FIGURE 8B

Inquiry Email (Form)

e-StellarNet

Provider Payment Status Inquiry Email

An email will be sent to **SUNNY@CSWL.COM** in the following format

Medical Payment Status

Date : 12/6/99

From : Sunny Paul(sunny@cswl.com)

RE: Employee Name: BOBO NEIL

Employer Name: MARINE WORLD

Claim No: 610061025996195

SSN: 389705260

Date of injury: 7/22/95

Please advise status on the following invoice:

Date of Service: 10/1/99

Account/Invoice no: 7A9832

Provider Name: DR. KEN ANDERSON

Provider TIN: CA1798321

Date of Invoice: 10/1/99

Bill Control Number: CNDAC10932

Comments : Thank you for your help

Send it | Cancel

Back | Home | Demo Menu

Pa

12
13
X

																
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

TO: SUNNY@CSWL.COM

Subject: Provider Payment Status Inquiry

12

From: Sunny Paul(sunny@cs.wt.com)

Employer Name: MARINE WORLD

Claim No : 610061029996195

SSN: 389705260

Date of Injury : 7/22/95

20

Date of Service : 10/1/99

Date of Invoice : 10/1/99

Account/Invoice no : 7A9832

Provider Name : Dr. KEN ANDERSON

Provider TIN: CA1798321

BILL CONTROL NUMBER: CMMC10932

Comments

Thank you for your help

Click

•

[illegible]

Response Form

e-StellarNet

Provider Payment Status Inquiry - Response Email Form

To Medical Facility : sunny@cswl.com

Bill Control No.(BCN) : CMMC10932 (For future reference please use the above BCN)

The status of above Invoice is:

- ☐ Our records indicate payment was released on 10/28/1999
- ☐ Our records indicate payment was paid in accordance with our contract agreement.
- ☐ No further payments are recommended
- ☐ Claim is currently under review for medical necessity
- ☐ Claim is currently under AOE/COE investigation.
- ☐ Claim was denied
- ☐ Necessity for this service is currently under review.
- ☐ No Policyholder Under This Name.
- ☐ We do not have coverage for this employer for this Date of Injury.
- ☐ No Industrial Injury Reported By Employer.
- ☐ Doctor's First Report Needed.
- ☐ Current Medical Report Needed.
- ☐ Itemized Statement Needed.
- ☐ Other _____

Next Page

Reset

Blackboard - Provider Portal

Bill Control No.(BCN): CMMC10932

Account/Invoice no : 7A9832
 Provider Name : Dr. KEN ANDERSON
 Date of Service : 10/11/99
 Claim Number : 610061029996195
 Date of injury : 7/22/95
 SSN : 389705260
 Employee Name : BOBO NEIL
 The status of above invoice is:

Our records indicate payment was released on 10/28/1999

SUNNY@CSWL.COM
Workers Compensation Medical Billing unit

Stellar Net Home Page



***StellarNet®**

*Internet solutions for the
workers' compensation community*

- Home
- Registration
- Submit Bills
- Pay Program
- Information
- New Members
- Press Releases

The steps to secure Internet processing of claims/bills & workers' compensation (WC) reports are as easy as 1, 2, 3. Register today & get control of the Paper Tiger!

TO DO THIS (using SSL? GO HERE)	RESULTS
1 Register on-line to submit bills and workers' compensation reports.	Registration You will receive an email confirming your registration & instructions on how to get started submitting bills
2 After receiving email confirmation & instructions, submit bills from existing medical billing software.	Submit Bills After bill submission, you will get an acknowledgement within 48 hours for your first submission, within 24 hours thereafter
3 After receiving email confirmation & instructions, download workers' compensation programs & instructions.	Download WC Programs After you download the WC programs, a key will be sent that permits you to unlock the programs & use them
• SSL-Secure Socket Layer encryption	Secure transmission of data

Click below for additional information:

- [Fees](#)
- [Terms and Conditions](#)
- [Privacy Policy](#)
- [Description of 1500 Data Elements](#)
- [Description of Bill Submission & WC Medical Reporting](#)
- [Payer Information & List of Electronic Payers/Receivers](#)
- [Provider Information](#)
- [Minimum System Configuration](#)
- [Glossary](#)
- [Demonstrations](#)

Other Features:

FIGURE 10A

StellarNet On-Line Bill Submission Form

e-StellarNet[®] On-Line Bill Submission

Welcome to StellarNet's on-line bill submission page. Please complete the form:

1. If you are not registered, [click here to go to registration page](#).
2. Registered members, proceed with bill submission:
 - a. Input your email address in the first box and click on "Report" to double check your membership status. If you are not registered, or if the email address is incorrect, you will get an error message.
 - b. To submit your bills use the "Browse..." button to select the name and location of the file(s) to submit. You can submit up to 3 files at one time.
 - c. To submit the bills, click "Upload file(s)" to submit bills

If you are a first time submitter, you will receive an acknowledgement back within 48 hours after you have submitted your first batch of bills. Thereafter, you will receive the acknowledgement back within 24 hours of submitting your bills.

Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.

Member
Upload
Password or
Email:

Files To Upload:

File 1:	<input type="text"/>	<input type="button" value="Browse"/>
File 2:	<input type="text"/>	<input type="button" value="Browse"/>
File 3:	<input type="text"/>	<input type="button" value="Browse"/>
<input type="button" value="Upload File(s)"/>		<input type="button" value="Reset Form"/>

Use browser's BACK button to return to previous page.

If you have any questions...

Call us at 415/882-5700, or Email us at rtvfast@ibm.net

FluE TOB

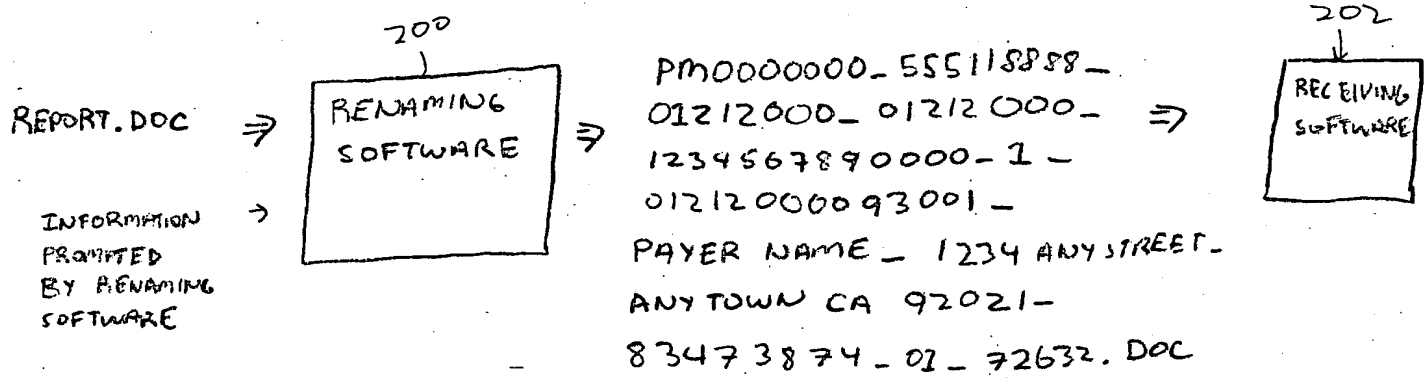


FIGURE 11

Field Name	Len	Type	Description / Example
Payer ID	9	Char	Electronic payer ID example: WACA02012. Print and mail payer ID is always PM0000000.
Patient's SSN	9	Char	Example: 123880000
Date of Injury	8	Char	MMDDYYYY Jan 20, 2000 example: 01202000
Date of Service	8	Char	MMDDYYYY Jan 21, 2000 example: 01212000
Type of Service	1	Char	1=Medical Care, 2=Surgery, 3=Consultation, 4=Diagnostic X-ray, 5= Diagnostic Laboratory, 6=Radiation Therapy, 7=Anesthesia, 8=Assistance at Surgery, 9=Other Medical Service, 0=Blood or Packed Red Cells, A=Used DME, F=Ambulatory Surgical Center, H=Hospice, L=Renal Supplies in the Home, M=Alternate Payment for Maintenance Dialysis, N=Kidney Donor, V=Pneumococcal Vaccine, Y=Second Opinion on Elective Surgery, Z=Third Opinion on Elective Surgery.
Provider Tax ID + Sub ID	13	Char	1234567890000 (use 0000 if not using sub ID)
Submit Date and Time	12	Char	MMDDCCYYHHMMSS Jan 22, 2000 9:30 01 am example: 01222000093001
Payer Name	25	Char	ABC WC PAYER
Payer Address	25	Char	100 MAIN STREET
Payer City State Zip	25	Char	BIG CITY NY 00030
Claim Number	28	Char	20303200223
Type of Document	2	Char	01=First Report, 02=Supplemental Report, 03=P&S Report, 04=QME, 05=Consult, 06=AME, 07=Entire File, 08=Diagnostic, 09=Chart Notes, 10=Pre-Authorization Request, 11=Referral Request, 12=Disability Status, 13=Surgical, 14=Ambulance, 15=Ancillary, 16=Home Care, 17=Other
ICD9	6	Char	Primary Diagnosis Code, no spaces no period on 5 digit codes.
Period	1	Char	. (also known as dot)
File Type	3	Char	Original file extension, DOC, RTF, TXT, etc.

FIGURE 12

E StellarNet Report Upload Site - Netscape

Location: <http://www.stellar.net.org/htol/en-reports.html>

On-Line WC Reports and Attachments Submission

Welcome to e-StellarNet's on-line report submission page. Please fill out this form completely for quick delivery to the proper administrator. [Democratization](#)
If you are not registered, [click here to register](#).

Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.

Member Upload Password or Email:

Locate Local Zip File of All Attachment Files or
Single Attachment File to Upload

Only fill out these following fields if
sending a single, non-zipped, attachment file.

Payer ID

Patient Social Security No

Date of Injury

Date of Service

Provider Tax ID

Type of Service Code

Your Initials and ID

Use browser's BACK button to return to previous page.

Document Done

FIGURE 13